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IN THE THIRD JUDICIAL DISTRICT COURT

SALT LAKE COUNTY, STATE OF UTAH

PLANNED PARENTHOOD
ASSOCIATION OF UTAH, on behalf of
itself and its patients, physicians, and staff,

Plaintiff,

vs.

STATE OF UTAH, *et al.*,

Defendants.

**BRIEF OF AMICI CURIAE IN
SUPPORT OF PLAINTIFF'S MOTION
FOR PRELIMINARY INJUNCTION**

Case No. 220903886

Judge Andrew Stone

TABLE OF CONTENTS

	Page
INTEREST OF AMICI CURIAE	1
INTRODUCTION AND SUMMARY OF ARGUMENT	2
ARGUMENT	4
I. Abortion Is a Safe, Common, and Essential Component of Health Care	4
II. Despite the Safe and Routine Nature of Abortions, Utah’s Criminal Abortion Ban Would Prohibit Nearly All Abortions with No Medical Justification.....	6
III. By Prohibiting Abortions, the Criminal Abortion Ban Will Harm Pregnant Patients’ Health.....	8
A. The Ban Will Endanger the Physical and Psychological Health of Pregnant Patients.....	9
B. The Narrow Exceptions to the Criminal Abortion Ban Do Not Adequately Protect Patients’ Health	13
IV. The Criminal Abortion Ban Will Hurt Rural, Minority, and Poor Patients the Most	15
V. The Criminal Abortion Ban Forces Clinicians To Make an Impossible Choice Between Upholding Their Ethical Obligations and Following the Law ...	17
A. The Criminal Abortion Ban Undermines the Patient-Physician Relationship by Substituting Flawed Legislative Judgment for a Physician’s Individualized Patient-Centered Counseling and by Creating Conflicts of Interest Between Physicians and their Patients	17
B. The Ban Violates the Principles of Beneficence and Non-Maleficence....	19
C. The Criminal Abortion Ban Violates the Ethical Principle of Respect for Patient Autonomy.....	20
CONCLUSION.....	21
CERTIFICATE OF SERVICE	22

TABLE OF AUTHORITIES

	Page(s)
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<i>Dobbs v. Jackson Women’s Health Organization</i> , 597 U.S. ___ (2022).....	3
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Amici Curiae the American College of Obstetricians and Gynecologists (“ACOG”), the American Medical Association (“AMA”), and the Society for Maternal-Fetal Medicine (“SMFM”) respectfully request leave to file the attached proposed Brief of *Amici Curiae* in Support of Plaintiff’s Motion for a Preliminary Injunction.

INTEREST OF AMICI CURIAE

ACOG is the nation’s leading group of physicians providing health care for women. With more than 62,000 members, ACOG advocates for quality health care for women, maintains the highest standards of clinical practice and continuing education of its members, promotes patient education, and increases awareness among its members and the public of the changing issues facing women’s health care. ACOG is committed to ensuring access to the full spectrum of evidence-based quality reproductive health care, including abortion care. ACOG has appeared as *amicus curiae* in courts throughout the country. ACOG’s briefs and medical practice guidelines have been cited by numerous authorities, including the U.S. Supreme Court, as a leading provider of authoritative scientific data regarding childbirth and abortion.¹

The AMA is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and

¹ See, e.g., *June Medical Servs. LLC v. Russo*, 140 S. Ct. 2103 (2020); *Whole Woman’s Health v. Hellerstedt*, 579 U.S. 582 (2016); *Stenberg v. Carhart*, 530 U.S. 914, 932-936 (2000) (quoting ACOG brief extensively and referring to ACOG as among the “significant medical authority” supporting the comparative safety of the abortion procedure at issue); *Hodgson v. Minnesota*, 497 U.S. 417, 454 n.38 (1990) (citing ACOG in assessing disputed parental notification requirement); *Simopoulos v. Virginia*, 462 U.S. 506, 517 (1983) (citing ACOG in discussing “accepted medical standards” for the provision of obstetric-gynecologic services, including abortions); see also *Gonzales v. Carhart*, 550 U.S. 124, 170-171, 175-178, 180 (2007) (Ginsburg, J., dissenting) (referring to ACOG as “experts” and repeatedly citing ACOG’s brief and congressional submissions regarding abortion procedure).

other physician groups seated in the AMA's House of Delegates, substantially all U.S. physicians, residents, and medical students are represented in the AMA's policymaking process. The objectives of the AMA are to promote the art and science of medicine and the betterment of public health. AMA members practice in all fields of medical specialization and in every state. The AMA's publications and amicus curiae briefs have been cited in cases implicating a variety of medical questions in courts across the U.S., including the U.S. Supreme Court. The AMA joins this brief on its own behalf and as a representative of the Litigation Center of the AMA and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state and the District of Columbia. Its purpose is to represent the viewpoint of organized medicine in the courts.

SMFM, founded in 1977, is the medical professional society for maternal-fetal medicine subspecialists, who are obstetricians with additional training in high-risk pregnancies. SMFM represents more than 5,500 members who care for high-risk pregnant people and provides education, promotes research, and engages in advocacy to advance optimal and equitable perinatal outcomes for all people who desire and experience pregnancy. SMFM and its members are dedicated to ensuring that all medically appropriate treatment options are available for individuals experiencing a high-risk pregnancy.

INTRODUCTION AND SUMMARY OF ARGUMENT

Abortion is an essential part of comprehensive health care. When abortion is legal, it is safe. *Amici curiae* are leading medical societies representing physicians, nurses, and other clinicians who serve patients in Utah and nationwide, and whose policies represent the

education, training, and experience of the vast majority of clinicians in this country. *Amici's* position is that state laws that criminalize and effectively ban abortion:

- (1) are not based on any medical or scientific rationale;
- (2) threaten the health of pregnant patients;
- (3) disproportionately harm patients of color, patients in rural settings, and patients with low income; and
- (4) impermissibly interfere with the patient-physician relationship and undermine longstanding principles of medical ethics.

As the AMA has recently recognized, “it is a violation of human rights when government intrudes into medicine and impedes access to safe, evidence-based reproductive health services, including abortion and contraception.”²

In the wake of *Dobbs v. Jackson Women’s Health Org.*, 597 U.S. ____ (2022), Utah now intends to enforce Utah Crim. Code § 76-7a-101, *et seq.* (the “Criminal Abortion Ban”), which imposes criminal penalties on individuals who provide abortions. The Criminal Abortion Ban was designed to become effective upon certification to the Legislative Management Committee by the legislative general counsel that “a court of binding authority has held that a state may prohibit the abortion of an unborn child at any time during the gestational period,” subject to certain exceptions.³

² AMA, *Press Release: AMA bolsters opposition to wider criminalization of reproductive health* (June 14, 2022), <https://www.ama-assn.org/press-center/press-releases/ama-bolsters-opposition-wider-criminalization-reproductive-health>.

³ 2020 Utah Laws Ch. 279, § 4(2).

Amici oppose Utah’s Criminal Abortion Ban because it would—without any valid medical justification—jeopardize the health and safety of pregnant people in Utah and place extreme burdens and risks upon providers of essential reproductive health care.

ARGUMENT

I. Abortion Is a Safe, Common, and Essential Component of Health Care

The medical community recognizes abortion as a safe and essential component of reproductive health care.⁴ Abortion is a common medical procedure. In 2020, over 930,000 abortions were performed nationwide.⁵ More than 2,700 abortions were performed in Utah in 2019.⁶ Approximately one quarter of American women have an abortion before the age of 45.⁷

The overwhelming weight of medical evidence conclusively demonstrates that abortion is a very safe medical procedure.⁸ Complication rates from abortion are extremely low, averaging

⁴ See, e.g., Editors of the *New England Journal of Medicine*, the American Board of Obstetrics and Gynecology, et al., *The Dangerous Threat to Roe v. Wade*, 381 *New Eng. J. Med.* 979 (2019) (stating the view of the Editors of the *New England Journal of Medicine* along with several key organizations in obstetrics, gynecology, and maternal-fetal medicine that “[a]ccess to legal and safe pregnancy termination ... is essential to the public health of women everywhere”); ACOG, *Abortion Policy* (revised and approved May 2022); Soc’y for Maternal-Fetal Med., *Access to Pregnancy Termination Services* (2017).

⁵ Jones et al., Guttmacher Inst., *Long-Term Decline in US Abortions Reverses, Showing Rising Need for Abortion as Supreme Court is Poised to Overturn Roe v. Wade* (June 15, 2022).

⁶ Utah Dep’t of Health, *Utah Vital Statistics: Abortions 2019*, at 20 (Nov. 2021), <https://vitalrecords.health.utah.gov/wp-content/uploads/Abortions-2019-Utah-Vital-Statistics.pdf>.

⁷ Jones & Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008-2014*, 107 *Am. J. Pub. Health* 1904, 1908 (2017).

⁸ See, e.g., National Academies of Sciences, Engineering, Medicine, *The Safety and Quality of Abortion Care in the United States* 10 (2018) (“*Safety and Quality of Abortion Care*”) (“The clinical evidence clearly shows that legal abortions in the United States—whether by medication, aspiration, D&E, or induction—are safe and effective. Serious complications are rare.”).

around 2%, and most complications are minor and easily treatable.⁹ Major complications from abortion are exceptionally rare, occurring in just 0.23 to 0.50% of instances across gestational ages and types of abortion methods.¹⁰ In 2019 there were only 5 abortions in Utah with reported complications, which was 0.2% of all abortions in Utah.¹¹ The risk of death from an abortion is even rarer: nationally, fewer than one in 100,000 patients die from an abortion-related complication.¹² By contrast, the “risk of death associated with childbirth [is] approximately 14 times higher.”¹³ In fact, abortion is so safe that there is a greater risk of complications or

⁹ See, e.g., Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 *Obstetrics & Gynecology* 175, 181 (2015) (finding 2.1% abortion-related complication rate); *Safety and Quality of Abortion Care*, at 55, 60.

¹⁰ White et al., *Complications from First-Trimester Aspiration Abortion: A Systematic Review of the Literature*, 92 *Contraception* 422, 434 (2015). This is also true for medication abortions, which account for more than 40 percent of all abortions in Utah and about half of abortions nationwide. Raymond et al., *First-Trimester Medical Abortion with Mifepristone 200 mg and Misoprostol: A Systematic Review*, 87 *Contraception* 26, 30 (2013) (regarding major complication rates for medication abortion); Utah Dep’t of Health, *Utah Vital Statistics: Abortions 2019*, *supra* note 6, at 24 (number of Utah medication abortions, category labeled “medical non-surgical”); Jones et al., Guttmacher Inst., *Medication Abortion Now Accounts for More than Half of All US Abortions* (Mar. 2, 2022) (nationwide data).

¹¹ Utah Dep’t of Health, *Utah Vital Statistics: Abortions 2019*, *supra* note 6, at 25.

¹² See Kortsmitt et al. U.S. Dep’t of Health & Human Services, Centers for Disease Control and Prevention, *Abortion Surveillance—United States, 2019*, 70 *Morbidity & Mortality Weekly Rep.* 1, 29 tbl. 15 (2021) (finding mortality rate from 0.00041% to 0.00078% for approximately five-year periods from 1978 to 2014); Zane et al., *Abortion-Related Mortality in the United States, 1998-2010*, 126 *Obstetrics & Gynecology* 258, 261 (2015) (noting an approximate 0.0007% mortality rate for abortion).

¹³ Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 *Obstetrics & Gynecology* 215, 216 (2012).

mortality for procedures like wisdom-tooth removal, cancer-screening colonoscopy, and plastic surgery.¹⁴

Similarly, there are no significant risks to mental health or psychological well-being resulting from abortion care. Recent long-term studies have found that women who obtain wanted abortions had “similar or better mental health outcomes than those who were denied a wanted abortion,” and that receiving an abortion did not increase the likelihood of developing symptoms associated with depression, anxiety, post-traumatic stress, or suicidal ideation compared to women who were forced to continue a pregnancy to term.¹⁵ One recent study noted that 95% of participants believed an abortion had been the “right decision for them” three years after the procedure.¹⁶

II. Despite the Safe and Routine Nature of Abortions, Utah’s Criminal Abortion Ban Would Prohibit Nearly All Abortions with No Medical Justification

Utah’s Criminal Abortion Ban will—without any valid medical justification—jeopardize the health and safety of pregnant people in Utah and place extreme burdens and risks upon

¹⁴ ANSIRH, *Safety of Abortion in the United States*, Issue Brief No. 6, at 2 (Dec. 2014) (2.1% of abortions result in minor or major complications—with 1.88% resulting in minor complications and 0.23% resulting in major complications—compared to 7% of wisdom-tooth extractions, 8-9% of tonsillectomies, and 29% of childbirths); American Soc’y for Gastrointestinal Endoscopy, *Complications of Colonoscopy*, 74 *Gastrointestinal Endoscopy* 745, 747 (2011) (33% of colonoscopies result in minor complications); Grazer & de Jong, *Fatal Outcomes from Liposuction: Census Survey of Cosmetic Surgeons*, 105 *Plastic & Reconstructive Surgery* 436, 441 (2000) (mortality rate from liposuction in late 1990s was 20 per 100,000); Kortsmit et al., *Abortion Surveillance—United States, 2019*, 70 *Morbidity & Mortality Weekly Rep.* 1, 29 tbl. 15 (2021) (mortality rate from legal induced abortion was between 0.52 and 0.63 per 100,000 in late 1990s, dropping to 0.41 in the years 2013-2018).

¹⁵ Biggs et al., *Women’s Mental Health and Well-Being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study*, 74 *JAMA Psychiatry* 169, 177 (2017).

¹⁶ Rocca et al., *Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study*, 10 *PLoS ONE* 1, 7 (2015).

providers of essential reproductive health care by criminalizing nearly all abortions.¹⁷ The State legislature offered no specific findings justifying its Criminal Abortion Ban, but in support of prior abortion restrictions, it has cited, *inter alia*, the State’s interest in saving the lives of pregnant women and “prevent[ing] grave damage to [pregnant women’s] medical health.”¹⁸ The Criminal Abortion Ban does not further those stated interests and is not medically justified. To the contrary, the Ban will harm the health of pregnant people in Utah, as described *infra* Part III, and creates arbitrary, unnecessary, and conflicting responsibilities for medical providers, see *infra* Parts III.B, V.

The Criminal Abortion Ban prohibits abortions,¹⁹ with only three narrow exceptions: (1) where the abortion is necessary to avoid death or “serious risk of substantial and irreversible impairment of a major bodily function”; (2) where two physicians who practice maternal-fetal medicine agree, in writing, that the fetus has a defect that is “uniformly diagnosable” and “uniformly lethal” or a “severe brain abnormality”—defined narrowly—that is “uniformly diagnosable”; and (3) where the pregnancy is the result of rape or incest **and** the physician who performs the abortion verifies that the rape or incest has been reported to law enforcement and complies with any additional reporting requirements.²⁰

¹⁷ The Criminal Abortion Ban’s definition of “abortion” includes that the termination be done “through a medical procedure carried out by a physician or through a substance used under the direction of a physician.” Utah Crim. Code § 76-7a-101(1)(a).

¹⁸ Utah Crim. Code § 76-7-301.1(4).

¹⁹ Utah Crim. Code § 76-7a-101(1)(a); *id.* § 76-7a-201(1).

²⁰ Utah Crim. Code § 76-7a-201(1).

The criminal penalties established by the Ban will prohibit nearly all abortions from occurring in the state. Individuals convicted of violating the Criminal Abortion Ban are subject to a penalty of one to fifteen years of imprisonment and a fine of up to \$10,000.²¹ Moreover, physicians and facilities risk losing their professional licenses under the Ban.²²

Prohibiting the vast majority of abortions deprives pregnant patients of important health care with no medical justification. Abortions are extremely safe,²³ and eliminating access to abortions does not improve the health of pregnant patients; rather, it jeopardizes their health and safety without advancing any legitimate medical interest and forces physicians to make the untenable choice between their ethical obligations to serve the best interest of their patients and their livelihoods.

III. By Prohibiting Abortions, the Criminal Abortion Ban Will Harm Pregnant Patients' Health

Utah's Criminal Abortion Ban would cause severe and detrimental physical and psychological health consequences for pregnant patients who want to obtain an abortion. First, while abortion is overall a safe medical procedure, the risk of complications and associated costs are lower the earlier the abortion is performed—and the Criminal Abortion Ban will likely cause delays in obtaining an abortion. Second, pregnant individuals may be more likely to attempt self-managed abortions using harmful or unsafe methods—that is, self-managed methods other than procuring appropriate medications through licensed providers.²⁴ Third, continuing a

²¹ Utah Crim. Code § 76-3-203(2); *see also id.* § 76-3-301(a).

²² Utah Crim. Code § 76-7a-201(4)-(5).

²³ *See supra* Part I.

²⁴ The safety of medication abortion is well established. *See supra* note 10.

pregnancy to term presents higher risk to the health and mortality of the pregnant patient than obtaining a safe, legal abortion. Each of these outcomes increases the likelihood of negative consequences to the patient's physical and psychological health that could be avoided if abortion were available.²⁵

The Criminal Abortion Ban's limited exceptions (defined *supra* Part II) are insufficient to protect the health of pregnant patients because they do not permit abortion care in a wide range of circumstances that could risk substantial harm to patients. They also contain elements that are too vague to provide workable guidance that clinicians can rely on when attempting to structure their practices in compliance with the Criminal Abortion Ban, and they compromise clinicians' ability to rely on their sound medical judgment to determine the best treatment plan and provide care.

A. *The Ban Will Endanger the Physical and Psychological Health of Pregnant Patients*

Criminalizing safe abortions provided by a licensed clinician in the State of Utah will likely result in delays in obtaining abortions. Typically, many delays in seeking an abortion are caused by the patient's lack of information about where to find abortion care.²⁶ The need to travel out of state and consider various states' individual criminal and/or civil penalties related to abortion is likely to further increase confusion for patients about where they can find needed health care. In addition, almost a third of delays are caused by travel and procedure costs.²⁷

²⁵ See, e.g., ACOG, Committee Opinion No. 815, *Increasing Access to Abortion* (Dec. 2020).

²⁶ Udapdhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104 Am. J. Pub. Health 1687, 1689 (Sept. 2014).

²⁷ *Id.*

With no in-state abortion providers, the travel and procedure costs for Utahns seeking abortion will likely increase. For example, a 2020 analysis demonstrated that the closure of Utah's abortion clinics would result in an over tenfold increase in the average required travel distance for Utahns seeking an abortion.²⁸ This distance could increase even further if states surrounding Utah, including Idaho, adopt similarly restrictive abortion bans. Though the risk of complications from abortion care overall remains exceedingly low, increasing gestational age results in an increased chance of a major complication.²⁹ Moreover, abortions at later gestational ages are typically more expensive, further increasing the barriers to obtaining care.³⁰

By removing access to safe, legal abortion, the Criminal Abortion Ban will also increase the possibility that a pregnant patient will attempt self-managed abortions through harmful or unsafe methods.³¹ Studies have found that women are more likely to self-manage abortions when they face barriers to reproductive services, and methods of self-management outside safe medical abortion (i.e., abortion by pill) may rely on harmful tactics such as herbal or

²⁸ Bearak et. al., Guttmacher Inst., *COVID-19 Abortion Bans Would Greatly Increase Driving Distances for Those Seeking Care* (updated Apr. 23, 2020) (finding that, on average, Utah abortion clinic closures would increase an abortion-seeking Utahn's driving distance from 27 miles to 299 miles).

²⁹ Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, *supra* note 9, at 181.

³⁰ Jones et al., *Legal Barriers to Second-Trimester Abortion Provision and Public Health Consequences*, 99 Am. J. Pub. Health 623, 624 (2009).

³¹ See, e.g., Jones et al., Guttmacher Inst., *Abortion Incidence and Service Availability in the United States, 2017*, at 3, 8 (2019) (noting a rise in patients who had attempted to self-manage an abortion, with highest proportions in the South and Midwest).

homeopathic remedies, intentional trauma to the abdomen, abusing alcohol or illicit drugs, or misusing dangerous hormonal pills.³²

Those patients who do not, or cannot, obtain an abortion due to the Criminal Abortion Ban will be forced to continue a pregnancy to term—an outcome with significantly greater risk to the health of the pregnant individual and of mortality. The U.S. mortality rate associated with live births from 1998 to 2005 was 8.8 deaths per 100,000 live births,³³ and rates have sharply increased since then.³⁴ In contrast, the mortality rate associated with abortions performed from 1998 to 2005 was 0.6 deaths per 100,000 procedures.³⁵ A pregnant patient’s risk of death associated with childbirth is approximately 14 times higher than any risk of death from an abortion.³⁶

Continued pregnancy and childbirth also entail other substantial health risks for the pregnant person. Even an uncomplicated pregnancy causes significant stress on the body and involves physiological and anatomical changes. Moreover, continuing a pregnancy to term can exacerbate underlying health conditions or cause new conditions. For example, approximately 6-7% of pregnancies are complicated by gestational diabetes mellitus, a condition which frequently

³² Grossman et al., *Tex. Pol’y Eval. Proj. Res., Knowledge, Opinion and Experience Related to Abortion Self-Induction in Texas* 3 (2015).

³³ Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, *supra* note 13, at 216.

³⁴ MacDorman et al., *Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends from Measurement Issues*, 128 *Obstetrics & Gynecology* 447 (2016) (finding a 26.6% increase in maternal mortality rates between 2000 and 2014).

³⁵ Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, *supra* note 13, at 216.

³⁶ *Id.*

leads to maternal and fetal complications, including developing diabetes later in life.³⁷

Preeclampsia, another relatively common complication, is a disorder associated with new-onset hypertension that occurs most often after 20 weeks of gestation and can result in blood pressure swings, heart disease, liver issues, and seizures, among other conditions.³⁸

Labor and delivery are likewise not without significant risk, including those of hemorrhage, placenta accreta spectrum (a potentially life-threatening complication that occurs when the placenta is unable to detach at childbirth), hysterectomy, cervical laceration, and debilitating postpartum pain, among others.³⁹ Approximately one in three people who give birth in the United States do so by cesarean delivery, a major surgical procedure that carries increased risk of complications.⁴⁰

Evidence also suggests that pregnant people denied abortions because of gestational age limits are more likely to experience negative psychological health outcomes—such as anxiety, lower self-esteem, and lower life satisfaction—than those who obtained a needed abortion.⁴¹

³⁷ ACOG Practice Bulletin No. 190, *Gestational Diabetes Mellitus* (Feb. 2018).

³⁸ ACOG Practice Bulletin No. 222, *Gestational Hypertension and Preeclampsia* (Dec. 2018).

³⁹ ACOG Practice Bulletin No. 183, *Postpartum Hemorrhage* (Oct. 2017); ACOG Obstetric Care Consensus, *Placenta Accreta Spectrum* (July 2012, reaff'd 2021); ACOG Practice Bulletin No. 198, *Prevention and Management of Obstetric Lacerations at Vaginal Delivery* (Sept. 2018); ACOG Clinical Consensus No. 1, *Pharmacologic Stepwise Multimodal Approach for Postpartum Pain Management* (Sept. 2021).

⁴⁰ CDC, *National Vital Statistics Reports Vol. 70, No. 2, Births: Final Data for 2019* (2021); ACOG, Obstetric Care Consensus No. 1, *Safe Prevention of the Primary Cesarean Delivery* (Mar. 2014, reaff'd 2016).

⁴¹ Biggs et al., *Women's Mental Health and Well-Being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study*, *supra* note 15, at 172.

B. *The Narrow Exceptions to the Criminal Abortion Ban Do Not Adequately Protect Patients' Health*

The narrow maternal health-related exceptions of the Criminal Abortion Ban are insufficient to protect the health of the pregnant patient. Pregnancy can exacerbate existing health issues that do not necessarily or always lead to death or permanent impairment of a major bodily function, but nevertheless pose serious health risks for patients during pregnancy. Examples include: Alport Syndrome (a form of kidney inflammation), valvular heart disease (abnormal leakage or partial closure of a heart valve), lupus (a connective tissue disease that may suddenly worsen during pregnancy and lead to blood clots and other serious complications), pulmonary hypertension (increased pressure within the lung's circulation system that can escalate during pregnancy), and diabetes (which can worsen to the point of causing blindness as a result of pregnancy).⁴²

Further, the Criminal Abortion Ban fails to take into account whether patients experienced issues that threatened their lives or the permanent impairment of a major bodily function during prior pregnancies. Any of these prior conditions can progress or reoccur if abortion care is not available. Various complications that present danger to the health of the pregnant patient also can directly affect fetal development and survival. For example, if a patient experiences premature rupture of membranes and infection, preeclampsia, placental abruption,

⁴² See Matsuo et al., *Alport Syndrome and Pregnancy*, 109 *Obstetrics & Gynecology* 531, 531 (Feb. 2007); Stout & Otto, *Pregnancy in Women with Valvular Heart Disease*, 93 *Heart Rev.* 552, 552 (May 2007); Cortes-Hernandez et al., *Clinical Predictors of Fetal and Maternal Outcome in Systemic Lupus Erythematosus: A Prospective Study of 103 Pregnancies*, 41 *Rheumatology* 643, 646-647 (2002); Kiely et al., *Pregnancy and Pulmonary Hypertension; A Practical Approach to Management*, 6 *Obstetric Med.* 144, 153 (2013); Greene & Ecker, *Abortion, Health and the Law*, 350 *New Eng. J. Med.* 184, 184 (2004).

and/or placenta accreta, that patient may be at risk of extensive blood loss, stroke, and/or septic shock, all of which would negatively affect the fetus. Each of these examples demonstrates why decisions about whether to continue a pregnancy are properly left with the clinicians and patients involved, rather than entrusted to legislators without reference to facts and medical evidence.

Other elements of the Criminal Abortion Ban's exceptions are equally problematic. For example, by limiting the maternal life and health exception only to death and "substantial and irreversible impairment of a major bodily function," the Criminal Abortion Ban fails to consider maternal mental health issues that can put a pregnant patient's health and life at risk.⁴³

Additionally, the requirement that two physicians agree in writing that a particular fetal defect or brain abnormality qualifies a patient for an abortion is a medically unnecessary roadblock to care, and the legislature's standards for what constitutes a qualifying defect or abnormality intrude on physicians' judgment and the patient-physician relationship. Not to mention that the narrow definition for fetal defect or brain abnormality may exclude a wide range of fetal anomalies that are serious, but not necessarily fatal.

Further, the exception for pregnancy resulting from rape or incest applies only where the patient seeking an abortion has reported (or has authorized the physician to report) the attack to law enforcement. This requires pregnant patients to choose between accessing the abortion services they need and their ability to maintain privacy and control over the intensely personal decision of whether and how to report their assault. This may dissuade patients from seeking an

⁴³ See, e.g., Mangla et al., *Maternal Self-Harm Deaths: An Unrecognized and Preventable Outcome*, 221 Am. J. Obstetrics & Gynecology 295 (2019).

abortion or endanger patients by forcing them to report an assault to law enforcement against their wishes.

It is untenable to force pregnant patients to wait until their medical condition escalates to the point that an abortion is necessary to prevent death or permanent injury to a major bodily function or life-sustaining organ before being able to seek potentially life-saving medical care. Nor should physicians be put in the impossible position of either letting a patient deteriorate until one of these narrow exceptions is met or face potential criminal punishment for providing medical care in contravention of the Criminal Abortion Ban. Indeed, that impossible choice could cause some physicians to second guess the necessity of critical abortion care until the pregnant patient has a serious medical complication or it is too late to save the pregnant patient's life. The limited exceptions described here indefensibly jeopardize patients' health.

IV. The Criminal Abortion Ban Will Hurt Rural, Minority, and Poor Patients the Most

The Ban will disproportionately impact people of color, those living in rural areas, and those with limited economic resources. *Amici* are opposed to abortion policies that increase the inequities that already plague the health care system in this country.

In Utah, approximately 27.1% of patients who obtained abortions in 2019 were Hispanic and approximately 4.8% were Black.⁴⁴ In addition, 75% of abortion patients nationwide are living at or below 200% of the federal poverty level.⁴⁵ Patients with limited means and patients living in geographically remote areas will be disproportionately affected by the closure of clinics,

⁴⁴ See Utah Dep't of Health, *Utah Vital Statistics: Abortions 2019*, *supra* note 6, at 20.

⁴⁵ Jerman et al., Guttmacher Inst., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008* (2016).

which requires them to travel longer distances (and pay higher associated costs) to obtain safe, legal abortions. These travel and procedure costs are compounded by the fact that other Utah laws create substantial financial barriers to abortion care (e.g., lack of coverage under insurance policies).⁴⁶

The inequities continue after an abortion is denied. As explained *supra* Part III.A, forcing patients to continue pregnancy increases their risk of complications, and the risk of death associated with childbirth is approximately 14 times higher than that associated with abortion. Nationwide, Black patients' pregnancy-related mortality rate is 3.2 to 3.5 times higher than that of white patients, with significant disparities persisting even in areas with the lowest overall mortality rates and among patients with higher levels of education.⁴⁷ Black patients in Utah experience severe maternal morbidity, defined as unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to health, at a rate 1.5 times higher than white patients,⁴⁸ making continuing an unwanted pregnancy to term disproportionately dangerous for them. The Ban thus exacerbates inequities in maternal health and reproductive health care, disproportionately harming the most vulnerable Utahns.

⁴⁶ Guttmacher Inst., *State Facts About Abortion: Utah* (June 2022).

⁴⁷ CDC, *Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths* (Sept. 5, 2019) (3.2 times); MacDorman et al., *Racial and Ethnic Disparities in Maternal Mortality in the United States Using Enhanced Vital Records, 2016-2017*, 11 *Am. J. Pub. Health* 1673, 1676-77 (Sept. 22, 2021) (3.55 times).

⁴⁸ Utah Dep't of Health, *A Utah Health Disparities Profile Maternal Mortality and Morbidity among Utah Minority Women*, at 16 (Jan. 2021), <https://healthequity.utah.gov/wp-content/uploads/2022/02/UtahHealthDisparitiesProfileMaternalMortalityMorbidity2021.pdf>.

V. The Criminal Abortion Ban Forces Clinicians To Make an Impossible Choice Between Upholding Their Ethical Obligations and Following the Law

Abortion bans such as the one at issue in this case violate long-established and widely accepted principles of medical ethics by: (1) substituting legislators’ opinions for a physician’s individualized patient-centered counseling and creating an inherent conflict of interest between patients and medical professionals; (2) asking medical professionals to violate the age-old principles of beneficence and non-maleficence; and (3) requiring medical professionals to ignore the ethical principle of respect for patient autonomy.

A. *The Criminal Abortion Ban Undermines the Patient-Physician Relationship by Substituting Flawed Legislative Judgment for a Physician’s Individualized Patient-Centered Counseling and by Creating Conflicts of Interest Between Physicians and their Patients*

The patient-physician relationship is critical for the provision of safe and quality medical care.⁴⁹ At the core of this relationship is the ability to counsel frankly and confidentially about important issues and concerns based on patients’ best medical interests with the best available scientific evidence.⁵⁰ ACOG’s Code of Professional Ethics states that “the welfare of the patient must form the basis of all medical judgments,” and that obstetrician-gynecologists should “exercise all reasonable means to ensure that the most appropriate care is provided to the

⁴⁹ ACOG, Statement of Policy, *Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (May 2013, reaff’d and amended Aug. 2021) (“*Legis. Policy Statement*”).

⁵⁰ AMA, *Patient-Physician Relationships, Code of Medical Ethics Opinion 1.1.1* (“The relationship between a patient and a physician is based on trust, which gives rise to physicians’ ethical responsibility to place patients’ welfare above the physician’s own self-interest or obligations to others, to use sound medical judgment on patients’ behalf, and to advocate for their patients’ welfare.”).

patient.”⁵¹ Likewise, the AMA Code of Medical Ethics places on physicians the “ethical responsibility to place patients’ welfare above the physician’s own self-interest or obligations to others.”⁵² The Criminal Abortion Ban forces physicians to supplant their own medical judgments—and their patients’ judgments—regarding what is in the patients’ best interests with the legislature’s non-expert decision regarding whether and when physicians may provide abortions.

As described above, abortions are safe, routine, and, for many patients, the best medical choice available for their specific health circumstances. There is no rational or legitimate basis for interfering with a physician’s ability to provide an abortion where both the physician and patient conclude that is the medically appropriate course. Laws that have the effect of banning abortion in nearly all circumstances are out of touch with the reality of contemporary medical practice and have no grounding in science or medicine.

The Criminal Abortion Ban also creates inherent conflicts of interest. Physicians need to be able to offer appropriate treatment options based on patients’ individualized interests without regard for the physicians’ own self-interest.⁵³ Here, however, by prohibiting physicians from performing abortions, the Utah Criminal Abortion Ban profoundly intrudes upon the patient-physician relationship. For example, if a patient’s health were compromised, the law would only allow an abortion in the face of death or substantial and irreversible impairment of a major bodily function, regardless of the overall medical advisability of the procedure or the desire of

⁵¹ ACOG, *Code of Professional Ethics 2* (Dec. 2018).

⁵² AMA, *Patient-Physician Relationships, Code of Medical Ethics Opinion 1.1.1*.

⁵³ See ACOG, *Legis. Policy Statement*, *supra* note 49.

the patient. A physician and patient together may conclude that an abortion was in the patient's best medical interests even though the risk posed by continuing the pregnancy does not rise to the narrow standard set forth in the Criminal Abortion Ban's exceptions. The Ban thus forces physicians to choose between the ethical practice of medicine—counseling and acting in their patients' best interest—and obeying the law.⁵⁴

B. *The Ban Violates the Principles of Beneficence and Non-Maleficence*

Beneficence, the obligation to promote the wellbeing of others, and non-maleficence, the obligation to do no harm and cause no injury, have been the cornerstones of the medical profession since the Hippocratic traditions nearly 2,500 years ago.⁵⁵ Both of these principles arise from the foundation of medical ethics which requires that the welfare of the patient forms the basis of all medical decision-making.⁵⁶

Obstetricians, gynecologists, and other clinicians providing abortion care respect these ethical duties by engaging in patient-centered counseling, providing patients with information about risks, benefits, and pregnancy options, and ultimately empowering patients to make a decision informed by both medical science and their individual lived experiences.⁵⁷

⁵⁴ Cf. AMA, *Patient Rights, Code of Medical Ethics Opinion 1.1.3* (“Patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician’s objective professional judgment.”).

⁵⁵ AMA, *Principles of Medical Ethics* (rev. June 2001); ACOG, Committee Opinion No. 390, *Ethical Decision Making in Obstetrics and Gynecology* 1, 3 (Dec. 2007, reaff’d 2016).

⁵⁶ See *supra* notes 49-52 and accompanying text.

⁵⁷ ACOG, Practice Bulletin No. 162: *Prenatal Diagnostic Testing for Genetic Disorders*, 127 *Obstetrics & Gynecology* e108 (May 2016).

The Criminal Abortion Ban pits physicians’ interests against those of their patients. If a clinician concludes that an abortion is medically advisable, the principles of beneficence and non-maleficence require the physician to recommend that course of treatment. And if a patient decides that an abortion is the best course of action, those principles require the physician to provide, or refer the patient for, that care. But the Criminal Abortion Ban, with its narrow medical exceptions, prohibits physicians from providing that treatment and exposes physicians to significant penalties if they do so. It therefore places physicians at the ethical impasse of choosing between providing the best available medical care and risking substantial penalties or protecting themselves personally. This dilemma challenges the very core of the Hippocratic Oath: “Do no harm.”

C. *The Criminal Abortion Ban Violates the Ethical Principle of Respect for Patient Autonomy*

Finally, a core principle of medical practice is patient autonomy—the respect for patients’ ultimate control over their bodies and right to a meaningful choice when making medical decisions.⁵⁸ Patient autonomy revolves around self-determination, which, in turn, is safeguarded by the ethical concept of informed consent and its rigorous application to a patient’s medical decisions.⁵⁹ The Criminal Abortion Ban would deny patients the right to make their own choices about health care if they decide they need to seek an abortion.

⁵⁸ ACOG, *Code of Professional Ethics*, *supra* note 51, at 1 (“respect for the right of individual patients to make their own choices about their health care (autonomy) is fundamental”).

⁵⁹ ACOG, Committee Opinion No. 819, *Informed Consent and Shared Decision Making in Obstetrics and Gynecology* (Feb. 2021); AMA, *Code of Medical Ethics Opinion 2.1.1*.

CONCLUSION

For the foregoing reasons, this Court should enjoin enforcement of the Criminal Abortion Ban.

RESPECTFULLY SUBMITTED this 8th day of July 2022.

/s/ David C. Reymann

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 8th day of July 2022, I electronically filed the foregoing **BRIEF OF AMICI CURIAE IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION**, which served all counsel of record.

/s/ David C. Reymann